Senate Bill (SB) 553
Working Group on the Implementation Planning for the Incorporation of Nursing and Choices for Independence Waiver Services in the NH Medicaid Care Management Program

Public Working Session
September 6, 2016
10:30 a.m. – 12:00 p.m.
Legislative Office Building, Rooms 210-211
Concord NH

Welcome/Introductions
Commissioner Jeffrey Meyers welcomed the working group and guests. The agenda was reviewed: Governor's Medicaid Care Management (MCM) Commission principles and recommendations will be presented by Doug McNutt, MCM Commission Member; Commissioner Meyers will discuss MCM procurement.

Presentation: Governor's Commission on Medicaid Care Management (MCM)
Doug McNutt, MCM Commission member, presented the Commission's Principles and Recommendations

Principles for a Medicaid Managed Long-Term Services and Supports Program: Promoting Health, Wellness, Independence, and Self-Sufficiency
The MCM Commission endorsed ten principles to inform and evaluate the transition from the current Medicaid-funded long term care system to a more efficient and effective Managed Medicaid Long Term Services and Supports (MLTSS) system and to ensure that individuals who rely on these services experience a smooth transition to MLTSS and maintain a high quality of care.
A handout (report submitted to the Governor last year) was provided listing the Principles with links to reports that informed the Commission's principles. Mr. McNutt reviewed each of the ten principles as follows:

1. Development and implementation of a quality MLTSS program requires a thoughtful and deliberative planning and design process. SB 553 planning fulfills this requirement
2. Implementation and operation of the MLTSS program must be consistent with the ADA and the Olmstead decision.
3. Payment structures should support the essential elements of the MLTSS program, encouraging home and community-based care and promoting employment services.
4. MLTSS participants must be assured the opportunity for informed choice and assistance thorough conflict-free education, enrollment assistance, and advocacy.
5. Consider the unique needs of the whole person. This is embodied in the developmental services program, but less so in elder services.
6. Ensure that one entity is responsible for an integrated package of acute care and LTSS.
7. Network adequacy must include the state's LTSS infrastructure and ensure participant a choice of and timely access to services and continuity during transition periods.
8. Must include defined participant protections and supports.
9. Quality of care must meet or exceed current standards.
10. Effective state oversight. Capacity in state government is vital to oversee this process.

Additional guidance is discussed in greater detail in the document with emphasis on adequate planning and conflict-free participant support.

Report to Governor Hassan: Recommendations in Medicaid Care Management: Lessons Learned from Acute Care: Transitions to Managed Long Term Supports and Services
Mr. McNutt summarized the Commission's recommendations. He acknowledged the Commission members as well as individuals who provided a broad range of expertise.

Recommendations:

- Planning now to assure quality of care and consumer protection in the future:
  1. Creation of an ongoing, multi-agency Senior Supports Cabinet to track demographics, update state policy, coordinated community awareness and strengthening of local supports.
  2. Committing to community supports for seniors. DHHS should develop coordinated oversight and administration of aging services.
  3. Creation of a strategic plan for the future of Medicaid
  4. Establish a DHHS Committee on consumer Protection in the Oversight of MLTSS.
  5. Planning for LTSS Financing, Addressing Concerns of Seniors to deal with the very complex financing mechanism for long term care services

- Establishing data collection systems and sufficient staffing to optimize Medicaid functioning:
  6. Assure availability and transparency of financial analysis and data
  7. Provide sufficient DHHS staffing to assure Medicaid efficiency and effectiveness

- Assuring that LTSS recipients receive appropriate care:
  8. Assurance of rate adequacy and network access for LTSS. A formal capacity assessment of the current system should be conducted to include a review of rate adequacy and network access barriers.
  9. Contract language to assure access to health resources and patient-centered medical homes. Include dually eligible and those with complex care needs.
  10. Identification of alternative payment models to promote medical/health homes and to support and enhance the LTSS services not provided in a medical setting.
  11. Assurance of best practices in care coordination for Step Two. The implementation of best practice quality strategies for LTSS is critical.
  12. Contract requirement for person-centered care with enrollee and advocate input. Consumer input is most important.
  13. Clearly define the difference between acute care utilization review and LTSS service planning.
  14. Avoid interruption of existing provider relationships for enrollees with complex needs
  15. Protect service continuity during transition to integrated LTSS. Should provide for a 12-month process so services are not interrupted, and MCOs would have to honor existing authorizations.
  16. MCM contracts to assure quality of care in behavioral health
  17. MCM contract to assure quality of care in long term supports and services. Quality arena in the long term care is not as developed as in the acute care setting. Caution should be taken in moving forward.

- Building and maintaining a strong provider network:
  18. DHHS engagement of Medicaid enrollees/advocates in defining Step Two Network Adequacy. Must consider the needs of populations who are dually eligible and/or have complex health needs when defining network adequacy.

19. Ongoing DHHS network adequacy evaluation through solicitation of and response to provider and enrollee concerns.

- Establishing strong relationships with Medicaid enrollees and effectively addressing concerns:
  20: Assuring effective communications between DHHS and LTSS recipients. The experience of Step 1 should inform the methods by which communication is carried out in Step 2.
  21. Requirements for enrollee complaint resolution.
  22. Preventing and addressing abuse, neglect, exploitation and complaints. This population is very vulnerable. Therefore, training and education to MCOs and providers is very important.
  23. Establishment of an LTSS ombudsman to adequately assure the rights of participants. The final federal rule address this
  24: Establishment of a system to respond to complaints and critical incidents to ensure issue resolution and systemic

The MCM Commission's report includes a discussion of "Critical Issues Needing Additional Attention," which include: (1) defining network adequacy; (2) assuring patient centered care (Step One) and/or person centered care (Step Two) for enrollees with complex care needs; (3) Defining and fully supporting service authorizations within MLTSS; (4) Implementing and supporting consumer protections; and (5) Fully Supporting behavioral health service needs.

Commissioner Meyers thanked Doug McNutt and MCM Commission Chair Mary Vallier-Kaplan for the tremendous body of work undertaken by the Commission. It will be very useful to the SB 553 working group and to the state overall.

Questions and Discussion:
Q: How is care coordination defined in terms of the differences between the CFI world of case managers and service coordinators as compared to the MCO world?
A: The Commission's information is premised on a presentation by Paul Saucier in which three types of models are discussed. There is no specific recommendation on a model.

Q: Why expand the MCOs' capacity instead of creating a separate program?
A: There are different models, and this is a public process to consider various models.

Comment: Appreciation was expressed for the mention of the population with complex medical needs.

Q: Explain the difference between network adequacy and network readiness, noting the difference between a list of providers and whether they can they get reimbursed. IT and financial capability can impact an organization taking on added costs.
A: The Commissioner stated that the Department is responsible for readiness review and assessment. CMS will review readiness at the federal level.

Comment: Beyond the adequacy of the network, there's a concern about downstream impact.
A: The MCOs must demonstrate their capacity to deliver the services. The Department will look at capacity and ensure that readiness is present.

Upcoming SB 553 Working Group Meeting Schedule
Presentations will continue to be provided in this forum. A schedule is being developed to cover pertinent topics. Including:

- MLTSS in other states - other models used and lessons learned
- CFI ICM review
- Nursing Facility Services overview
- Impact of the federal Managed care rule
- Rate setting process and rate adequacy is for LTSS
- Quality presentation
- Current contract position relative to case management, care coordination, and quality. CC may be a topic of its own.
- DHHS work to date on Step Two implementation

As previously mentioned, the focus is on CFI and nursing first, and waivered services next.

Procurement Process
Commissioner Meyers provided background on reprocurement. SB 147, passed, in 2011, contemplated an initial five-year managed care program. The program was delayed and therefore has been in effect for just short of three years. It must be recognized that the Program is still in its initial phase, and the department is balancing its desire to honor the terms and intent of the contracts, wanting to reprocure to improve program, while developing plans for Step Two services.

To give this process time to develop, the Department wishes to extend the current contract for a final one-year period (currently set to expire June 30, 2017). DHHS proposes going back to Governor and Council to propose a one-year extension through June 30, 2018.

The Department will work with the Legislature, the new Governor, Executive Council, and all stakeholders. A well-defined process will be put in place to obtain input from the public as well. This will include obtaining comment on an RFP in order to issue a final RFP around May 1, 2017. Additional time will be needed to respond and vet the contracts. Efforts will be made to take advantage of what has been experienced in other states.

Comments:
Q: Does the reprocurement affect the implementation date of Step Two by 2017?
A: Implementation dates are not included in the MCO agreements. Senator Forrester's bill prohibited implementation dates. Instead the Legislature allowed DHHS to undertake the SB 553 process to develop a plan with stakeholders for Step Two.
Q: Is DHHS contemplating a rate increase for the one-year extension? Is there anything to direct MCOs to increase rates for Direct Service Providers?
A: Rates are not set. The process will be driven by an actuarial practice.

Adjourn. Next meeting: September 15th.